TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOTEXAS PHYSICIANS & SURGEONS

Respondent Name
GREAT DIVIDE INSURANCE COMPANY

MFDR Tracking Number
M4-17-2830-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "this claim was originally submitted without A9999 x 2 in error which has been added to support he heel cup (DME) & heel wedge (DME) given to the patient at this visit."

Amount in Dispute: $40.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is not a re-consideration because codes have been added. This request for reconsideration is improper because it added billing codes to the request in contravention of Rule 133.304(k) and it is being treated as an incomplete bill per Rule 133.304(1)."

Response Submitted by: Berkley Specialty

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2017	Durable Medical Equipment Heel Cup & Heel Wedge, A9999 (2 units)	$40.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
5. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
6. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced or denied.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY. PLEASE SEE SPECIAL *NOTE* BELOW.
   - B19 – REDUCTIONS TAKEN ACCORDING TO OCCUNET.

Issues

1. Is the patient enrolled in a certified Worker's Compensation Health Care Network?
2. Are the disputed services subject to a contract?
3. Did the insurance carrier support treating the bill as incomplete?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment for the services in dispute?

Findings

1. Review of records held by the division finds no notification to the division that the insurance carrier has enrolled the injured employee in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The response does not include any documentation to support that the injured employee is enrolled in a certified HCN. The respondent does not state that the employee is enrolled in a certified HCN on the explanation of benefits.

   28 Texas Administrative Code §133.240(f)(15) requires that the paper form of an explanation of benefits shall include the "workers' compensation health care network name (if applicable)." Review of the submitted explanation of benefits (EOB) finds that the field indicating "PPO Subnet" is blank.

   28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   As the respondent has not presented any information to the requestor regarding a certified HCN, the Division concludes the respondent has waived the right to raise any such defense. Any newly raised denial reasons or defenses shall not be considered in this review.

   Labor Code §413.031(a)(1) states that a health care provider is entitled to a review of a medical service provided if a health care provider is "denied payment or paid a reduced amount for the medical service rendered."

   Labor Code §413.031(c) further states that "in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules."

   The Texas Workers' Compensation Act entitles health care providers to a review of medical services it they are denied payment. The Act further grants the division authority to resolve such disputes and adjudicate any payment. For these reasons, the division has jurisdiction to review the disputed medical fee issues.

2. The insurance carrier denied or reduced payment with claim adjustment reason code B19 – "REDUCTIONS TAKEN ACCORDING TO OCCUNET." The respondent did not present any documentation to support that the disputed services were subject to a contract between the parties to this dispute. The disputed services will therefore be reviewed per applicable division rules and fee guidelines.

3. The insurance carrier's response states that Rule §133.250 does not exist. The division takes notice that Rule §133.250 does exist The provisions of Rule §133.250 were adopted to be effective May 2, 2006, see 31 *Texas Register* 3544; amended to be effective July 1, 2012, see 37 *Texas Register* 2408; the current version of this rule amended to be effective March 30, 2014, see 39 *Texas Register* 2095.

   Additionally, the respondent cites Rule §133.304(k) and (1) as reason to deny the request as improper and to treat the bill as an incomplete bill. Rule §133.304 was repealed, effective May 1, 2006. The respondent is advised to review the *Texas Register* for the current division rules, or please refer to the division's website where a copy of the most current rules are available at: http://www.tdi.texas.gov//wc/rules/documents/wcrules.pdf

4. The disputed items are durable medical equipment billed under code A9999 (2 units) for a Heel Cup & Heel Wedge. Medicare does not assign a value to these items and the division has not established a medical fee guideline for them either.

   Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   28 Texas Administrative Code §134.1(f) requires that:

   > Fair and reasonable reimbursement shall:
   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

   Texas Labor Code §413.011(d) requires that:

   > Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide:

   > documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

   The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

5. The division first reviews the information presented by the requestor to determine whether it has met the burden to show that the payment amount it is seeking is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, then the division will review the respondent's evidence.

   Review of the submitted documentation finds that:

   - The requestor did not submit any information to support a fair and reasonable price for the disputed items.
   - The table of disputed services indicates that the amount in dispute for the items is the amount billed.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). While durable medical equipment is not the same as an inpatient hospital admission, the above principle is of similar concern in the present case. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Thus, payment of the billed charges is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider—which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. Therefore, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is submitted to support that the payment amount sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not explain or provide documentation to support how the requested payment amount ensures quality medical care to injured workers.
   - The requestor did not explain or provide documentation to support how the proposed payment amount achieves effective medical cost control.
   - The requestor did not explain or provide documentation to support how the requested payment amount ensures that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not explain or provide documentation to support that the requested payment amount is consistent with the criteria of Labor Code §413.011.
   - The requestor did not explain or provide documentation to support that the requested payment amount satisfies the requirements of Rule §134.1.

   The request for additional reimbursement is not supported. After thorough review of the submitted information, the division concludes the requestor has failed to discuss, demonstrate, and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.